General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Murrays Pharmacy, St John's Medical Centre, Bromyard Road, WORCESTER, WR2 5FB

Pharmacy reference: 1121146

Type of pharmacy: Community

Date of inspection: 12/02/2020

Pharmacy context

This is a community pharmacy inter-connected with a medical centre in the western suburbs of the city of Worcester. A wide variety of people use the pharmacy. It dispenses NHS and private prescriptions and sells over-the-counter medicines. The pharmacy also supplies several medicines in multi-compartment compliance aids to help vulnerable people in their own homes to take their medicines. And, it supplies medicines to the residents of a few small care homes.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	2.2	Good practice	The team members are encouraged to develop and keep their skills up to date and they are given time at work to do this.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy offers a range of services and everyone can access these.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy's working practices are generally safe and effective. It is appropriately insured to protect people if things go wrong. The pharmacy keeps the up-to-date records that it must by law. The team members keep people's private information safe and they know how to protect vulnerable people. But, they could be better at recording and learning from mistakes to prevent them from happening again.

Inspector's evidence

The pharmacy team identified and managed most risks. Dispensing errors and incidents were recorded electronically. The last error had occurred in December 2019. An incident report had been completed but, on the day of the visit, the staff did not know how to access the details of this. Near misses were also recorded electronically. These could be accessed. But, in January 2020, only two errors had been recorded. One was a labelling error and one a strength error. Neither entry included sufficient information to allow any useful analysis. No learning points or actions taken to reduce the likelihood of similar recurrences were recorded. And, the log was not reviewed or discussed with the staff. The pharmacist said that the electronic recording procedure did not encourage all near misses to be documented because the pharmacy was busy and the computers were in constant use for dispensing purposes. He said that he would investigate using a paper version for recording any near misses and then upload this electronically when time allowed.

The dispensary was organised. There was a front pharmacist and checking area. Behind this was the main labelling and assembly area. A small area to the side and back of the dispensary was used for multi-compartment compliance aids. There was also an area for deliveries to patients. A shelf above the assembly area was used for prescriptions waiting to be checked. Several of these were seen to be stored on top of one another. This increased the risk of errors. However, the regular pharmacist said that he only placed one basket at a time in the checking area to mitigate this risk.

Coloured baskets were used and distinguished prescriptions for patients who were waiting, those for collection, those for delivery and those which had items owed to patients. There was a clear audit trail of the dispensing process and all the 'dispensed by' and checked by' boxes on the labels examined had been initialled. Three independent people were involved in the dispensing process, except for the compliance aids. This reduced the risk of errors. The pharmacist said that he would extend this good practice to the compliance aids.

Up-to-date and relevant standard operating procedures (SOPs) were in place. These were kept and signed electronically. The SOPs were reviewed every two years, or sooner, if necessary, by the superintendent pharmacist. The roles and responsibilities were set out in the SOPs and the staff were clear about their roles. There was a displayed list of 'red card substances', the sale of which should be referred to the pharmacist, such as 'prescription only medicine' (POM) to 'pharmacy only medicine' (P) switches. A medicine counter assistant said that she would refer all medicine sale requests for patients who were also taking prescribed medicines, to the pharmacist. She knew that fluconazole capsules should not be sold to women over the age of 60 or under the age of 16 for the treatment of vaginal thrush.

The staff were clear about the complaints procedure and reported that feedback on all concerns was

actively encouraged. The pharmacy did an annual customer satisfaction survey. In the 2019 survey, 98% of people who completed the questionnaire rated the pharmacy as excellent or very good overall. There had been some feedback about waiting times and communication with the surgery. The pharmacist said that most complaints that the pharmacy received related to the re-ordering time schedule for repeat prescriptions. Because of this, the pharmacy had displayed a notice asking patients to allow a week for their medicines to be ready after they had ordered the prescriptions. The pharmacist said that there was some confusion because the surgery stated that prescriptions would be ready in 72 hours. So, the pharmacy staff explained to people that was when the prescription would be generated and not when the medicines would be ready for collection at the pharmacy.

Public liability and professional indemnity insurance, provided by the National Pharmacy Association and valid until 31 December 2020, was in place. The responsible pharmacist log, controlled drug (CD) records, including patient-returns, private prescription records, emergency supply records, specials records, fridge temperature records and date checking records were all in order.

An information governance procedure was in place and the staff had also completed training on the general data protection regulations. The computers, which were not visible to the customers, were password protected. Confidential information was stored securely. Confidential waste paper information was collected for appropriate disposal. No conversations could be overheard in the consultation room.

The staff understood safeguarding issues and had read the company's procedures on the safeguarding of both children and vulnerable adults. The pharmacists and technicians had also completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. Local telephone numbers to escalate any concerns relating to both children and adults were available online. All the staff had completed 'Dementia Friends' training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. And, the company provides additional support when team members are on holiday, extended leave or off sick. The team members are encouraged to develop and keep their skills up to date and they are given time at work to do this. They are comfortable about providing feedback to the pharmacist to improve services for patients and he acts on this.

Inspector's evidence

The pharmacy was inter-connected with a medical centre. They mainly dispensed NHS prescriptions with the majority of these being repeats. But, due to their location, they did have a number of acute 'walk-in' patients. Several domiciliary patients and a few care home patients received their medicines in multi-compartment compliance aids.

The current staffing profile was one full-time pharmacist, one part-time pharmacist (1.5 days a week), one full-time NVQ3 qualified technician, three full-time NVQ2 qualified dispensers and one part-time medicine counter assistant. One dispenser was off sick and one was on holiday on the day of the visit. These hours were being covered by a relief staff. An accuracy checking technician (ACT) was on extended leave and the full-time technician was covering these hours. Planned leave was booked well in advance and only one member of the dispensary staff could be off at one time. A staffing rota was used to ensure appropriate staffing levels with the desired skill mix.

The staff worked well together as a team. Staff performance was monitored, reviewed and discussed informally throughout the year. Performance appraisals were undertaken by a member of staff from the company's head office. But, the regular employed pharmacist had not had a formal appraisal for about five years. The other staff did have one-to-one meetings with someone from their head office. The staff were encouraged with learning and development and completed e-Learning, such as recently on controlled rugs. They said that they spent about 30 minutes each month of protected time learning. The GPhC registrants reported that all learning was documented on their continuing professional development (CPD) records.

The staff knew how to raise a concern and said that this was encouraged and acted on. The MCA had recently raised an issue with finding prescriptions that had items owed to patients. Because of this, the pharmacy now placed these in green baskets so that they were easy to locate. There were 'ad hoc' staff meetings. The regular pharmacist said that he would introduce monthly meetings and use these to discuss errors and any other issues. He said that he was set targets, such as for Medicine Use Reviews (MURs), but that he only did clinically appropriate reviews and did not feel unduly pressured by the targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy looks professional and is suitable for the services it offers. It signposts its consultation room well, so it is clear to people that there is somewhere private for them to talk.

Inspector's evidence

The pharmacy was well laid out and presented a professional image. Some of the areas had baskets, waiting to be checked, stored on top of one another, which increased the risk of errors. The pharmacist said that he would review the pharmacy's procedures for downloading and assembling many prescriptions at one time. This should ease the situation of baskets stored on top of one another. The floors in the pharmacy were clear. The premises were clean and well maintained.

The consultation room was spacious and well signposted. It contained a computer, a sink and three chairs. Conversations in the consultation room could not be overheard. The pharmacy computer screens were not visible to customers. The telephone was cordless and all sensitive calls were taken in the consultation room or out of earshot.

There was air conditioning and the temperature in the pharmacy was below 25 degrees Celsius. There was good lighting throughout. Most items for sale were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of services and everyone can access these. It manages its services effectively to make sure that they are delivered safely. The team members make sure that people have the information that they need to use their medicines properly. The pharmacy gets its medicines from appropriate sources. And, it stores and disposes of them safely. The team members make sure that people only get medicines or devices that are safe.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room with an automatic opening door from both the surgery and the pavement. The staff could access an electronic translation application for use by non-English speakers. The pharmacy could print large labels for sight-impaired patients. A portable hearing loop was available.

Advanced and enhanced NHS services offered by the pharmacy were Medicines Use Reviews (MURs), New Medicine Service (NMS), supervised consumption of methadone and buprenorphine, needle exchange, emergency hormonal contraception (EHC), the Community Pharmacy Consultation Service (CPCS) and seasonal flu vaccinations. The latter was also provided under a private scheme. The services were well displayed and the staff were aware of the services offered.

The pharmacist had completed suitable training for the provision of seasonal flu vaccinations including face to face training on injection technique, needle stick injuries and anaphylaxis. He had also completed suitable training for the provision of the free NHS EHC service and the new CPCS scheme. The pharmacist said that most referrals for the later were received on Saturdays.

The pharmacy currently had few substance misuse patients. There was a dedicated folder for these patients where the prescriptions and any relevant information was kept. Any concerns about these patients would be recorded on their prescription medication records. Any supervised patients were offered water or engaged in conversation to reduce the likelihood of diversion.

Several domiciliary patients and a few care home patients received their medicines in compliance aids. These were assembled in a small separate area, on a four-week rolling basis and evenly distributed throughout the week to manage the workload. There were dedicated folders for these patients where all the relevant information such as hospital discharge sheets and changes in dose were kept. These were referred to at the checking stage. Changes were also recorded on the patient's prescription medication record. The compliance aids were transported to the front bench for checking. The pharmacist said that he would look moving the current delivery area elsewhere to allow a dedicated checking area to be created for the compliance aids, away from distractions of the front bench. The assembled compliance aids were stored tidily. Procedures were in place to ensure that all patients, who had their medicines in compliance aids and were prescribed high-risk drugs, were having the required blood tests.

There was a good audit trail for all items ordered on behalf of patients by the pharmacy and for all items dispensed by the pharmacy. Interventions were seen to be recorded on the patient's prescription medication record. Green 'see the pharmacist' stickers were used. The pharmacist routinely counselled

patients prescribed high-risk drugs such as warfarin and lithium. International normalised ratios (INR) were asked about. The pharmacist also counselled patients prescribed amongst others, antibiotics, new drugs, any changes and those with complex instructions. CDs and insulin were packed in clear bags and these were checked with the patient on hand-out. The staff were aware of the sodium valproate guidance relating to the pregnancy protection programme. 'At risk' patients were counselled and cards were included with each prescription for them.

All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist. Signatures were obtained indicating the safe delivery of all medicines and owing slips were used for any items owed to patients. The pharmacist said that he gave advice about the timings of medicines and advice on inhaler technique during MURs. He also gave healthy living advice to diabetic patients and sometimes identified side effects such as, swollen ankles in patients prescribed amlodipine. If he was concerned about anyone, he would refer them to their doctor.

Medicines and medical devices were obtained from AAH, Phoenix, Alliance Healthcare and Murrays warehouse. Specials were obtained from Rokshaw Laboratories. Invoices for all these suppliers were available. A scanner to check for falsified medicines, as required by the Falsified Medicines Directive (FMD), was installed but not yet operational. CDs were stored tidily in accordance with the regulations and access to the cabinets was appropriate. There were a few patient-returned and out-of-date CDs. These were clearly labelled and separated from usable stock. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with electronic records. Electronic date checking procedures were in place. Designated bins were available for medicine waste and used. There was a separate bin for cytotoxic and cytostatic substances and a list of such substances that should be treated as hazardous for waste purposes.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts were received electronically, printed off and the stock checked. They were signed and dated by the person checking the alert. Any required actions were recorded. The pharmacy had received an alert on 3 February 2020 about ranitidine tablets. The pharmacy had none in stock and this was recorded. The pharmacy staff had also read a communication from the Department of Health and Social care, sent on 7 February 2020, about coronavirus.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities for the services it provides. And, the team members make sure that they are clean and fit-for-purpose.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (5 - 500ml) There were several tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 78 and the 2019/2020 Children's BNF. There was access to the internet.

The fridges were in good working order and maximum and minimum temperatures were recorded daily. The pharmacy computers were password protected and not visible to the public. There was a cordless telephone and any sensitive calls were taken in the consultation room or out of earshot. Confidential waste information was collected for appropriate disposal. The door was always closed when the consultation room was in use and no conversations could be overheard.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.